515 may last 9 months, there is very little bathing, and only hands are washed, in muddy water brought from the river or
514 brook, before and after meals. There are no latrine ditches. Feces are deposited behind thorny bushes 1/4 mile from the hamlet at most, while urination at night proceeds within the hamlet. This practice is followed even in towns and in Addis Ababa. Fortunately the strong sun carbonizes the feces in the dry season, and the strong rain in that season sweeps it away. There is no caste of sweepers, and no attention is paid to human or animal feces, except for the manure of oxen and cows. The latter is hand-pressed into cakes and used as fuel.

364 Hyenas, jackals and vultures are not interfered
825 with, as their services in removing carcasses of animal origin are well appreciated.

165 Abundant sunlight during 9 months of the year, coupled with the scanty clothing of small children, probably gives them their best chance of survival in addition to the long breast-feeding. Nevertheless infant mortality is very high, and in an average family half the babies born die before reaching the age of 5.

164 Flea infestation of humans can be described as
136 complete. This opens the way to flea-born typhus, especially on the highland plateau. Lice are somewhat less general, since they are not regarded by the Amhara as inevitable as fleas. Thus, an Amhara whose hair is infected
136 with lice (e.g. during a stay in prisons which are always
164 lice-infected), he may shave his hair. But louse-born re-
744 lapsing fever epidemics recur from time to time, and the

1: Messing E-5 (1953-1954)1957 MP5 Amhara MP5

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[749] government has now made free injections available at "big markets" of provincial towns. Bedbugs are also prevalent, of the bloodsucking variety. They are considered a nussance by the Amhara, but all that is done is to air the "alga" bed in the sunlight, which merely reduces the infestation temporarily. Flies are also abundant and very aggressive, so that a flyswitch ("cher") is kept in motion for comfort. Contagious diseases spread readily. Just after each rainy season, malarial mosquitoes have caused epidemics up to levels of 5,000 feet, on the shore of overflowing lakes and rivers.

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[231] In the majority of cases, some livestock is taken into the living hut (tuqul) everynight. The tuqul has, of course, an unwashable mud floor, no windows or chimney, soot-blackened ceiling, cobwebs in corners. There is no change of clothing at night, merely an added "kutta" or sheepskin, against the cold. Aside from drinking cups, there are no individual utensils.

164
[548] Towns, including provincial towns, are centers for the spread of syphilis and other venereal diseases, due to the existence of entire streets of "women in-between marriages" who act as restauranteurs-prostitutes. When surface lesions appear, the native "wogasha" is consulted; or since the Italian invasion made the "needle" popular, the modern government medical personnel is approached. But patients usually cease to continue treatment when surface lesions disappear.[67]

[759] Eating "brundo", raw beef, at feasts, almost always leads to tapeworm and other taenia infestation. Fortunately

67. Guthe, Th: Venerial Disease in Ethiopia. W.H.O. Bulletin, Vol.2, 1949, pp. 85-138.

797 ish surgeon, Kurt Hanner. In 1927, the
743 American Presbyterian Mission opened a 100-bed hospital at Gullale on the outskirts of the capital. This hospital was staffed with American Mission doctors. In 1934 the "Zauditu Memorial Hospital" was founded by the Government. This hospital was run by the Seventh-Day Adventists chiefly as a maternity hospital. Helped by the American Society for Lepers, the Sudan Interior Mission and the Ethiopian Government, in 1934, founded a leprosarium at Akaki, near Addis Ababa. In
[874] 1935, the beginning of a school for "Medical Assistants" was set up in the Menelik Lycee, but this work was interrupted by the war. In the interior of Ethiopia medicine had also progressed. There were a number of mission hospitals, of which the most important were the Swedish Mission Hospital (Tafari Makonnen) in Harar and another Swedish Mission Hospital in Lekemti. The French Railroad had its own hospital in Diredawa.

●744 Public health work was still very primitive. A public health committee, consisting of three physicians and a pharmacist, had been set up in Addis Ababa as the "Commission de l'Hygiène Publique." This com-

[p. 711a]

744 mittee was presided over by the Minister of the Interior and a number of public health laws had been issued.

It will thus be seen that in the short period of his reign from 1930 to 1935, when the Italo-Ethiopian War broke out, Emperor Haile Selassie I had achieved considerable improvement in the medical situation. It has often been stated by Italian writers that Ethiopia had no medical facilities whatsoever. Comparisons are constantly being made with what Italy had to offer its citizens in the medical field, not with what was offered at this period to Africans in the surrounding countries.

During the Italo-Ethiopian War, medical services in Ethiopia were found totally inadequate to help the country in its defense. An appeal went out through the International Red Cross, and a large number of countries contributed Red Cross ambulances with medical staffs to Ethiopia. Foremost among these were Great Britain, Holland, Sweden and Norway. After the defeat of the Ethiopian forces, most of this foreign personnel had to leave and the Italians set up a new medical organization.

It is not necessary to discuss here in any detail the medical services in Ethiopia

[p.711b]

744 during the Italian occupation, 1936 to 1941. The first year of the "conquest" was considered "a period of orientation and preparation." Demobilization of the Italian military sanitary service was carried out, while the civilian organization had not as yet been completed.

743 In the whole of East Africa, the Italians had a medical staff of approximately 1,000 men. The provinces comprising Italian East Africa were: (1) Eritrea somewhat larger than before, (2) Somalia, (3) Shoa, (4) Harar, (5) Amara, and (6) Galla and Sidamo. The Italians had the problem of making the country safe for their own people. A large number of hospitals, dispensaries and mobile sanitary units were set up. The plan called for a large (at least 600 beds) regional hospital in each of the six regions. None of the regional hospitals in Ethiopia were finished, but some, like the one in the Galla Sidamo region (Jimma), were already partly in use at the time of the Italian defeat. The Italians have made much capital out of the "civilizing effort in the field of medicine." It is true that the figures for treatment of sick persons supplied by Italian medical authorities, indicate a great deal of interest in the native population. This interest must, however, be taken with a grain of salt on the basis of actual findings on the spot. For example, it is indicated almost constantly that a very much larger number of natives received hospital treatment than did Italians. When the U. S. Technical Project examined the hospital in Jimma, it was, however, discovered that, while a grandiose hospital had been under development for the Italians, no real hospital existed for the Ethiopians, apart from some temporary, insanitary buildings. These barracks carried a magnificent name and figured with a large number of beds for natives in the Italian reports, but the obvious fact was that essentially nothing had been done for the native population.

114 Much nosological work was prepared by the Italians in the different regions of

[p. 712 A]

10: Barkhuis D-5 (1944-1945) 1947
MP5 Amhara MP5

114 Ethiopia. Eritrea and especially Italian Somaliland had been used by the School of Tropical Medicine in Bologna as a study ground, and to this was now added the much more varied and interesting field of Ethiopian nosography. The Italian studies, amounting to over 500, have been carefully analyzed by the U. S. Technical Project in Ethiopia. With few exceptions, especially in the field of malariology, the Italian work was careless, inexact, with a tendency to unwarranted generalizations.

While a number of excellent Italian physicians worked in East Africa, it would seem that, on the whole, publication was not encouraged unless it would further the Fascist cause. It would thus not be justified to judge Italian medical work here solely on the writings of the more politically minded party members. It does, however, remain a fact that, considering the very large group of medical men who worked in Ethiopia for over five years, we have precious little exact medical information about this country.

744 759 Today, the medical services of Ethiopia are being reorganized. The Government is attempting to obtain the necessary medical personnel, build hospitals and carry out public health programs. It is still too early to judge any achievements. The problems are many and the Ethiopian Government is handicapped through the complete lack of native Ethiopian physicians. Such physicians will not be available for at least another decade.

114 During and after World War II, military authorities had reason to take an interest in Ethiopian nosography and a number of articles were published in this field; prominent among these was Manson-Bahr's "The Prevalent Diseases of Italian East Africa" (1941). The U. S. Technical Project had opportunity to make a number of its own studies and much of the following information is based on this work.

164 If one may speak of social diseases in the sense of diseases of immediate impor-

[p. 712B]

10: Barkhuis D-5 (1944-1945) 1947
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164 The epidemiology of diphtheria in Africa is still little known. Schick tests have shown high immunity among Ethiopian children, but the occurrence of cases of clinical diphtheria in the native population is unknown.

Every year rabies has claimed a large number of Ethiopians. Until 1927 no treatment was available nearer than Cairo. [744] Since then, treatment has been given in Addis Ababa. The number of rabid dogs in Ethiopia is very large, but little is known of the number of persons bitten outside the capital. It is estimated that approximately 100 persons receive treatment in Addis Ababa every month.

Dengue is common in the northern part of the Harar plateau. It was found quite commonly among Italians at Diredawa and I can remember several fellow travelers coming down with this disease after a night spent in that town. Some control has been attempted since 1943, but until a health service is organized, effective control will not be possible.

Disease terms in Amharic:

164 192 A number of diseases have clear terms in the Amharic language. Of the venereal diseases, syphilis is referred to as *kitigne* in its early form while later manifestations are called *worde*. The rheumatic pains, *kurtemaat*, so frequently complained of, are often syphilitic. Gonorrhoea is generally called *chapto* (actually to squeeze, or it squeezes me). The word for malaria is *wobah* (r). *Nidad* (i.e., it caught fire) is also used, but may be used for several types of fever. Relapsing fever is called *mitch* and is generally differentiated by the population from typhus fever which is called *tessibo*. Smallpox is called *fantata* and chicken-pox is recognized as a distinct disease called *kuffin*. Diarrhoea is called *tekmat*, which literally means "what makes to sit down." In asking a patient whether he has fever, the word *tekusat* is used. The patient with fever will generally have put a band dipped in cold water around his head.

[A723B]

11:Levine Z-4,5 (1958-1961)1965 MP5 Amhara MP5

*565 121 178 181 [212] [577] been employed as a medium for promulgating new ideas or discussing contemporary problems. Another feature of Amhara culture that helps to account for the mental inertia of the peasantry is its emphasis on the value of deference and obedience to authority. The Amhara typically rely on legitimate authority figures to define appropriate responses to new situations, and regard the delegation of powers as a diminution of the status of such authorities. The peasant has thus refrained from initiating changes in the public domain because the prerogative of taking initiative is generally reserved to ecclesiastical and political authorities.

*565 121 177 178 *Receptivity to Change*

Consideration of the peasant's readiness to follow the lead of legitimate authorities already points to an inadequacy of the second stereotype we have mentioned: that which sees the peasant as hopelessly ignorant and backward, hence intractable from the viewpoint of a program of modernization. For while the Amhara peasant is likely to resist the efforts of some unknown official from Addis Ababa to introduce change in his local environment, he does tend to follow the directives and imitate the example of the local authorities whom he knows and who shape the course of decisions and sanctions at the [137] local level. Thus it is, for example, that the eucalyptus tree—imported by Emperor Menelik, taken to the provinces by nobles, and eventually planted by individual peasants—has come to dot the Amhara countryside. How quickly such change can take place is shown by the recent acceptance of photography in many provincial regions. In 1950, peasants in many Amhara areas strenuously objected to having their pictures taken, in part at least for fear of the camera as bearer of the evil eye. By 1960, visitors to some of these same areas were being deluged with requests for photographs. In the interim these peasants had been exposed to numerous photographs of the Emperor and high government officials and had observed their local authorities seizing every chance they could to be photographed.

Yet it is clear that the Amhara peasant will not imitate everything that is accepted by his traditional authorities. When a new custom strikes him as too outlandish his resistance can become adamant, as was abundantly demonstrated when the court of Susneyos carried out its ill-fated conversion to Catholicism. In analyzing the peasant's receptivity to change it is important to distinguish as independent variables: (1) the degree of acceptability of the *agents* of change, and (2) the extent to which the proposed change is congruent with traditional beliefs and values.

The whole question of the nature of peasant opposition and receptivity to modernizing programs may be discussed most realistically by focusing on a concrete area of attempted change. The material I have assembled is most [744] detailed for the case of public health, an area to which the government has

11:Levine Z-4,5 (1958-1961)1965 MP5 Amhara MP5

paid increased attention in recent years. A new phase of public health endeavor in this decade was marked by the imposition of a nationwide health tax in 1960.

Health has become a prime objective in Ethiopia's modernization program because of a growing realization that the wide prevalence of malaria, tuberculosis, typhus, intestinal parasites, syphilis, trachoma, leprosy, and other diseases continues to sap the vitality of the nation's productive forces and to visit misery on countless peasant families. The public health forces in Ethiopia (Ministry of Public Health, WHO mission, and AID Public Health Division) have long understood that Ethiopia's health needs cannot be met by piecemeal therapy. They have undertaken a program of preventive measures by preparing public health teams in the medical college at Gondar. The college trains health officers, community nurses, and sanitarians within a common framework, so that when they go into the field they will understand each other's tasks from the start. The first public health center employing such a team was opened in the late fifties; Ethiopia's Second Five-Year Plan envisions one such center for every fifty thousand people by 1967.

The objective of these public health workers is to transmit a number of instructions—concerning personal hygiene, environmental sanitation, early care for illness, and isolation of contagious diseases—which are at variance with customary beliefs and practices. Experience with comparable programs elsewhere suggests that the success of such health teams is by no means assured.[18] What are the forces working for and against the acceptance of these new instructions by the Amhara peasantry? Both negative and positive factors may be identified with respect to each of the three general categories previously referred to: the general outlook regarding change; attitudes toward the agents of change; and degree of compatibility between the new cultural items and the old.

The Amhara peasant's general resistance to change may be presumed operative here as elsewhere, particularly since health practices are often associated with religious beliefs and sentiments. Defense of indigenous therapies has in fact become a significant channel for the expression of traditionalist sentiment, a channel that has even been utilized on occasion in the Addis Ababa newspapers.[19] And a general posture of resistance to changes in the field of health is supported by the interests of traditional practitioners, *dabtarā* and *tanqudy*, who are in danger of losing clientele if modern-trained health workers come to win their allegiance.

Counter to this conservative drag, on the other hand, is the peasant's powerful desire for one basic change in his life circumstances, namely, the reduction of morbidity and mortality. Despite his idyllic conception of paradise and his frequent contention that life on earth is something of little value, the Amhara wants to avoid death. Even from the religious point of view he is

11:Levine Z-4,5 (1958-1961)1965 MP5 Amhara MP5

*565 121 177 178 75 761 motivated to live as long as possible: the monk wants to live longer in order to get closer to God by prayer, and the worldly man wants to live long enough to atone for his sins so that he may enter paradise. Health thus rates as one of the most important values. The expressions for greeting and farewell stress health. Most of the prayers and vows offered have to do with achieving health. Long, painful pilgrimages are made for cures, and much money is spent for the remedies of native practitioners and for amulets to ward off illness. This powerful desire for health and life operates as a lever to overcome the resistance to change.

*565 121 177 829 Toward the bearers of new ideas designed to satisfy this desire for reduced morbidity and mortality, however, the peasant's stance is suspicious and unsympathetic at the outset. He regards Ethiopians who have been educated by Westerners as contaminated by alien norms and beliefs. They appear to him as Ethiopians, but also as strangers—as "black *faranj*"—with their European clothes and their unorthodox eating and smoking habits. He tends to distrust their motives, to suspect them of being out to take advantage of him in some way. And he resents their overt or implicit disparagement of his way of life, particularly his practices in so sensitive an area as sanitation.

*565 121 177 744 [554] Against such obstacles one cultural factor that serves to present the health worker as an acceptable agent of change is the Amhara peasant's deference to the man of learning. The public health worker is in a position to inherit some of the awe felt for the learned *dabtarā*, especially since the health teams operate out of centers which provide therapy as well as instruction, which gives them the benefit of association with the quasi-magical powers attributed to one who performs successful treatment. In addition, he can be aided by the Amhara peasant's personal devotion to someone who has helped him and won his confidence. Whether this devotion can be stimulated depends, in the last analysis, on the character and resourcefulness of the public health workers themselves. Those who are able to communicate in a dignified manner with the peasants, who avoid dealing with them as an inferior and backward people, who refrain from flaunting the most important local norms, and who are on good terms with local authorities and respected men, have a substantial chance of being accepted after an initial period of suspicion and alienation. Thus it was that a Gojjami peasant, asked why some of the local people were hearkening to the advice of the public health team at Dabra Marqos, explained: "We have come to realize that what you tell us to do is for our own advantage, not yours." Elsewhere in Gojjam, a similar response was the eventual issue of a more pronounced initial rejection of public health workers. In the village of Dajan doors were closed against a venereal disease team which was taking blood samples of the entire population for Kahn test analysis. Popular suspicion was voiced in a number of ways; the health workers were accused of selling blood, of being missionaries, and of otherwise trying

11:Levine Z-4,5 (1958-1961)1965 MP5 Amhara MP5

to cheat the locals. The health officer in charge of the team then brought some of the objectors to the mobile laboratory, patiently explained what was going on, and how it would benefit the people. Before long word got around that these outsiders were not so evil after all, and the doors of Dajan opened.

Given the possibility that the Amhara peasant may come to acknowledge the public health worker as a legitimate agent of change, what about the discrepancy between the ideas advanced by the public health workers and the ideas of his traditional culture? The conception of the causation of illness is radically different in the two cultures. Since the peasant views the etiology of disease as a function of the will of supernatural beings, on what grounds could he adhere to prophylactic measures based on naturalistic conceptions?

Valid though our characterization of the peasant's concept of causation may be, it is nevertheless a very simplified one. It is unlikely that any world view is totally devoid of some sort of naturalistic explanations, just as, conversely, well-educated moderns often cling to residues of "superstition." Though the Amhara's general framework for understanding causation is not naturalistic, he does possess a number of specific notions which can be interpreted as naturalistic or protonaturalistic. Here are some examples:

(1) The belief that an excessively dirty house brings sickness (even though in practice animals are permitted to urinate and defecate indoors and strings of soot to hang from the rafters).

(2) A vague notion that the daily washing of hands, mouth, and feet is related to health.

(3) The concept of *metch*, an ailment involving fever and pains, believed to come from exposure to dirty places as well as excessive exposure to the sun (though the devil is often thought to be the conveyer of the ailment).

(4) The concept of *gershā*, a notion that a convalescent is liable to relapse unless he refrains from eating unaccustomed foods, resumes work slowly, stays out of the sun, and washes his body and clothes.

(5) A latent concept of contagion, found in: (a) the belief that smelling the urine of another will give one a cold, (b) the belief that the breath of a typhus patient will communicate his disease, and (c) the custom of referring to all diseases which can be given by one person to another as "*zār* sickness."

Even when the explanations set forth by the health workers deviate too much from what the peasant can possibly conceive as plausible, there may still be grounds to justify his accepting some strange advice through an appeal to more familiar beliefs and interests less directly related to the matter at hand. Thus, while peasants have been reluctant to accept the sanitarian's argument that diseases will be prevented by sanitizing the water supply through building wells, they have often been persuaded to build wells by the prospect of securing a more convenient source of water.

Measuring the relative strength of forces supporting and opposing change